# RESISTING OCCUPATION IN KASHMIR

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CHAPTER 4

# From "Terrorist" to "Terrorized"

## *How Trauma Became the Language of Suffering in Kashmir*

SAIBA VARMA

### On the Front Lines

"What happens when an entire society is suffering from PTSD?" asks a 2009 article on mental health in Kashmir, published by the Dart Center of Journalism and Trauma at Columbia University (Matloff and Nickelsberg 2009). The article—which describes a lone psychiatrist overwhelmed with treating a suicidal patient, a woman who thinks her murdered brother follows her around, and a former detainee who is too scared to stay home—exemplifies a genre of writing on Kashmir in the post-2002 period. In these writings, the effects of long-term violence, militarization, and occupation are understood through psychological suffering, particularly trauma and post-traumatic stress disorder (PTSD).[1]

Building on a key ethnographic commitment in this edited volume to chronicle "the lived contradictions of an occupying power" (Bhan, Duschinski, and Zia, this volume), this chapter examines the blurring of military and humanitarian efforts in Kashmir, particularly the use of psychiatric and psychological technologies to heal populations under occupation, and also shows how trauma and PTSD in particular have become important tools for redressing widespread political alienation in Kashmir.

Globally, trauma and PTSD have emerged as urgent public health concerns in the aftermath of natural disasters, wars, and other complex

emergencies through medical humanitarian organizations. Early research on PTSD focused on populations who had experienced violence and displacement and who were recipients of humanitarian relief (Mollica, Wyshak, and Lavelle 1987). However, after the Bosnian War, humanitarian organizations began focusing their emergency relief projects around trauma and PTSD. Today, while controversy exists regarding appropriate, culturally sensitive responses to PTSD, the disorder has become a fundamental part of humanitarian assistance globally (Breslau 2004). The recognition of trauma and PTSD in Kashmir can be partly attributed to these global trends in medical humanitarianism, but the shift from the language of terror to that of trauma is also shaped by local and national politics. Drawing on eighteen months of ethnographic fieldwork conducted between 2009 and 2011 in Kashmir Valley, I show how the widespread use of trauma and PTSD in Kashmir indicates the emergence of medical humanitarianism as a mode of governance in the region in the early 2000s. According to the Kashmiri psychiatrists whom I interviewed, because the last decade has seen an overall drop in rates of physical violence, the psychological scars of long-term violence became more visible. Before this, people were too preoccupied with matters of life and death to "worry about trauma," as one psychiatrist put it.

Psychiatrists recalled the difficulty of treating and raising awareness around mental health and trauma related to the conflict. By the late 1990s, first thousands and then hundreds of thousands of patients were flooding the Institute of Mental Health and Neuro Sciences (formerly the Government Psychiatric Diseases hospital) in Srinagar's old city—the only standalone psychiatric facility in the state—with complaints of traumatic stress. At the time, the hospital existed only as a skeletal version of itself. It had been burned down in a fire in March 1996, and the entire hospital's functions were reduced to a single Out Patient Department the size of one doctor's chambers. Long-term patients were housed in a dilapidated shed on the premises. Psychiatrists working at the hospital during this time described feeling overwhelmed and ill-equipped to handle the deluge of patients suffering from trauma. After seeing the extent of psychological problems related to violence, many psychiatrists felt that they were on the "front lines" of the conflict.

In the following years, medical humanitarianism in Kashmir Valley, particularly interventions around mental health, trauma, and PTSD, have exploded as a response to skyrocketing rates of trauma, PTSD, and substance abuse. Medical humanitarianism in Kashmir today is multifaceted; it consists of efforts by international humanitarian organizations such as Médecins sans

Frontières (MSF), known in English as Doctors without Borders; local organizations such as the Help Foundation; the Jammu and Kashmir (J&K) police and military establishments; and Kashmiri psychiatrists, all of whom have different interests and goals in treating and publicizing trauma and PTSD.

Although PTSD originally appeared as a psychiatric diagnosis in the United States through progressive social movements demanding rights, particularly for women and veterans who have suffered violence (Fassin and Rechtman 2009), in Kashmir, trauma and PTSD are not only used for progressive political or social ends. Medical humanitarian organizations such as the MSF have used trauma and PTSD to argue for an ongoing mental health crisis in the region and to justify their ongoing intervention. Trauma and PTSD have also appeared in arguments highlighting human rights violations in Kashmir, where they are used as evidence for the illegitimacy and violence of Indian military occupation. Simultaneously, the J&K Police have used trauma therapies as tools of counterinsurgency. Finally, Kashmiri psychiatrists have embraced trauma and PTSD to advance Kashmiri psychiatry as a global form of expertise. In chronicling the proliferation of the use of trauma and PTSD across these sites, I show how trauma has gained wide usage beyond a clinical diagnosis. The term "trauma" has rhetorical power in Kashmir, but its analytical power is diluted due to its multiple, varying usages.

In tracing the emergence of a trauma epidemic in Kashmir as well as subsequent (mis)uses of trauma and PTSD, I want to assert that I do not question the realness of the suffering that people have experienced and continue to experience in Kashmir on a daily basis due to ongoing conditions of violence, militarization, and occupation. During my fieldwork at various sites of mental health care, I listened to countless stories of how violence has deeply affected people's lives, families, and communities. What was abundantly clear from those experiences was that there is a dire need for people's suffering to be recognized and treated, including through biomedical channels. However, what I do want to probe here are the implications of using trauma and PTSD to make political claims, including when trauma therapies are imagined by the state as alternatives to political solutions. In the fifteen or so years since the language of trauma and PTSD first appeared in Kashmir, do these terms still represent or reflect the everyday reality of Kashmiris under long-term colonial occupation?

The use of the English-language term "trauma" is a product of complex cultural, linguistic, and symbolic translations. No Kashmiri patient I encountered ever described her or himself as "traumatized." The diagnosis

of traumatic stress was a translation of local idioms of distress that I heard in clinical settings, such as *kamzori* (weakness) and *tang* (restlessness). This process of translation has real material implications for how state agencies and nongovernmental organizations distribute and manage care and material goods as well as who in Kashmir gets read as an "authentic" and deserving victim. As Derek Summerfield (2012, 520) has argued, what is at stake in the rise of trauma and PTSD globally is a transformation of the everyday, where "medico-therapeutic ways of seeing have come to dominate everyday descriptions for the vicissitudes of life and the vocabulary of distress." Here, I am concerned not only with the construction of a public health crisis based on Western ideas of mental illness and traumatic stress but also with how this crisis and its redress are woven into the structure of military governance.

## An Epidemic of Trauma

In Kashmir, the terms "trauma" and "PTSD" first appeared through medical humanitarian efforts in the early 2000s. In November 2000, Kashmiri mental health experts and MSF staff conducted a joint seminar to "increase awareness and knowledge among health professionals of [traumatic] stress related psychosocial complaints and identify possible fields of action for MSF" (Scholte 2001, 65). Medical professionals at the meeting estimated that approximately 30–40 percent of the general population was suffering from psychiatric problems, with the majority suffering from anxiety disorders, depression, and PTSD (65). In July 2001 in collaboration with the government medical college, the MSF started a pilot project to provide mental health services in the Ganderbal District. The project's goal was "to establish a system for dealing with the psycho-social problems evident in the area. Due to long term social upheaval, the area population is suffering from traumatic stress, depression and psychosocial problems (e.g. substance abuse, domestic violence)" (Médecins sans Frontières 2001). The MSF worked closely together with the J&K state government to put trauma and PTSD at the center of its public health agenda.

The language in the MSF's report carefully avoids the terms "conflict" and "violence," instead choosing to describe the region as mired in "long term social upheaval." This deliberate depoliticization of the conflict, understanding it as a "social" rather than political struggle, reflects the ethics of humanitarianism more broadly—namely, the attempt to separate humanitarian

action from the sphere of politics. However, the statement also underscores how humanitarian organizations such as the MSF depend on nation-states for their continued work, particularly when those states are robust. According to a report published on its website, the MSF had tried to work in Kashmir since 1995, but it was only in 2000 that the MSF was "allowed permanent presence by giving training and implementing health care programmes" in collaboration with the Voluntary Health Association, a state agency (Médecins sans Frontières 2001).

In subsequent years, the MSF has played a highly significant role in measuring and treating trauma through awareness-raising programs, counseling and psychotherapy services, and epidemiological reports on mental health (de Jong et al. 2008a; de Jong et al. 2008b; see also Varma 2012). These efforts in effect produced trauma and PTSD as objects of urgent medical intervention, to which the MSF was well positioned to respond. For example, one report (Médecins sans Frontières 2006) found that a third of its respondents suffered from psychological distress, and almost half (48.1 percent) of all respondents reported that they only occasionally or never felt safe. While the MSF has provided treatment to thousands of people suffering from psychological distress, many living with no mental health services whatsoever, its focus on trauma and PTSD also served as justifications for its ongoing presence in Kashmir. For example, the organization's experience of providing emergency relief to victims in the aftermath of the 2005 South Asia earthquake, which affected both Pakistan and Indian-occupied Kashmir, was used to underscore the need for more psychological counseling in the region.[2]

As scholars of humanitarianism have argued, viewing natural disasters, wars, and the outbreak of disease as "emergencies" has been central to global humanitarian activities since the end of the Cold War. Craig Calhoun argues that understanding events as wide ranging as natural disasters, wars, and famines under the category of "emergency" is a way of "imagining . . . that emphasizes their apparent unpredictability, abnormality and brevity, and that carries the corollary that response—intervention—is necessary. The international emergency, it is implied, both can and should be managed" (Calhoun 2006). In the case of the Kashmir earthquake, as with many other global emergencies, intervention begot further intervention. An MSF report from October 2005 describes how "MSF activities around Chirunda [in the Uri District] have almost completed . . . with 3500 people . . . receiving shelter material, shoes for children and blankets, and 700 tents . . . distributed" (Médecins sans

Frontières 2005). The report also includes plans for future interventions. MSF medical team is screening the villagers and will monitor the health status of the population—in particular children under five—during the winter. A community based mental health program will be started after training counselors." These narratives are evidence for the increasing rationalization and professionalization of humanitarian organizations such as the MSF on a global scale, but they also create a sense of "crisis" that is necessary for the MSF's mission as an emergency relief organization.

The media also helped shape the "epidemic" of trauma under way in the aftermath of the earthquake. Local news stories covering earthquake victims described how "traumatized survivors [were] thronging to mosques and the few psychiatric wards as they [tried] to grapple with the mental shocks of Kashmir's devastating earthquake" (Ahmed 2005). Such scenes and images of crowds of people "thronging" to the psychiatric hospital became a steady feature in local and international news reports on Kashmir in the following years and contributed to the sense described earlier that psychiatrists were under siege (Hashmi 2007; Matloff and Nickelsberg 2009). Together, media accounts as well as reports by organizations such as the MSF helped establish the sense that "an entire society [is] suffering from PTSD."

From 2005 on, the MSF expanded its mental health programs and advocacy across Kashmir Valley. The organization, along with others such as Action Aid International, established counseling centers in a number of government-run hospitals. The MSF also produced a weekly radio program called *Alaw Bay Alaw* (Call Brother Call) focusing on topics including stress, relaxation techniques, depression, and drug abuse (Hamdani 2003). In an article in *Greater Kashmir* celebrating World Mental Health Day on October 10, 2010, Dr. Mushtaq Margoob, then head of the Department of Psychiatry, articulated the need to focus on mental health as a direct effect of the conflict. "We have had a generation of people who have seen the worst of the times. They are now getting into their adulthood. So keeping that in view, it is time to address the issues concerning mental health in Kashmir for the well-being of the affected people" (Aslam 2010). Such statements underscored how the effects of long-term violence were increasingly understood medically, specifically psychologically—a process that Didier Fassin and Richard Rechtman (2009, 23) have called the "traumatization of experience." The efforts of humanitarian organizations in treating and publicizing mental health care also revealed how trauma and PTSD were becoming major public health concerns in post-cease-fire Kashmir.

## Trauma as a Marker of Human Rights Violations

Reports of widespread mental illnesses, particularly those based on traumatic stress, caused by violence and militarization also filtered into human rights reports. Human rights reports described widespread insomnia, learning disabilities, anxiety disorders, and even a local idiom of distress known as "midnight knock syndrome," the fear of predawn raids conducted by Indian security forces during the height of violence to root out militants hiding in homes. In human rights and media accounts, these psychiatric and psychological problems are generally viewed as coterminous with trauma.

However, within human rights, trauma and PTSD have been used for different ends than what humanitarian organizations such as the MSF have used them for. Trauma's utility in human rights discourses in Kashmir and elsewhere might stem from the fact that it is the only psychiatric diagnosis where trauma "is both the product of an experience of inhumanity and the proof of the humanity of those who have endured it" (Fassin and Rechtman 2009, 20). As such, the language of trauma has also emerged as a rhetorical tool used by the political establishment to assert empathy with victims of violence and to underscore the long-term and insidious effects of occupation. This turn to trauma is in line with tightening regulations in international humanitarian and human rights law in which trauma—particularly if supported by wounds and scars on the body—constitutes one of the few forms of recognition and "proof" of political persecution (Fassin and d'Halluin 2007).

However, in surveying human rights reports from the 1990s, I found almost no references to trauma, PTSD, or even psychological suffering. Human rights reports from the 1990s are instead full of details of physical violence committed by Indian security forces and, to a lesser extent, militant groups. For example, in its 1993 report *Rape in Kashmir: A Crime of War*, Asia Watch (a division of Human Rights Watch) and Physicians for Human Rights (1993a) chronicled fifteen cases of rape, forty-four extrajudicial executions, eight cases of torture, and twenty injuries resulting from indiscriminate shootings of noncombatants. There is only one reference to psychological trauma in another report by Asia Watch and Physicians for Human Rights (1993b), a recommendation to establish a center for victims of physical and psychological trauma.

By the early 2000s the content of human rights reports had shifted somewhat, perhaps due to the emergence of a trauma narrative in Kashmir more generally. Human rights organizations argued that not only acts of physical

brutality but also the "culture of fear" produced by such acts violated international law (International People's Tribunal on Human Rights and Justice in Indian-Administered Kashmir and Association of Parents of Disappeared Persons 2012). Unlike earlier reports, which focused on specific violations, including rape, forced disappearances, illegal detention, and torture, Human Rights Watch's 2006 report is titled *Everyone Lives in Fear*. According to this report, not only violations but also the fear of violations haunt the everyday lives of Kashmiris:

> Suspicion and fear continue to permeate the Kashmir Valley. A knock on the door late at night sends spasms of anxiety through households, afraid that a family member will be asked by the security forces or militants to step outside for "a minute" and then never return. The bombs of militants go off in crowded markets without any warning. Psychological trauma related to the violence has been enormous, as life itself is constantly under threat. (Human Rights Watch 2006)

In human rights reports, trauma and PTSD were used to argue for the need to restore civic rights and provide legal redress to victims of violence in Kashmir, which the state had failed to do. Rights advocates argued that not only were Kashmiris traumatized by the conflict, but the lack of accountability of Indian security forces in the region also had a direct effect on the well-being of civilians. As one Kashmiri commentator argued, psychological wounds were produced by violence, but they were also caused by patterns of impunity on the part of the Indian military (Hashmi 2007). As such, revealing the psychological effects of impunity was also a way of questioning Indian rule.

Similarly, in 2010 a national Indian human rights organization, the Human Rights Law Network, which has a branch in Srinagar, and Act Now for Harmony and Democracy, an Indian organization established in the aftermath of the 2002 Gujarat genocide, convened an Independent People's Tribunal on Human Rights Violations in Kashmir in the Broadway hotel in central Srinagar. During the two-day event, victims of violence from across the valley came forward and gave heartbreaking testimonies about kin who had been disappeared, cases of custodial torture and mistreatment, and rape. The published report of the proceedings (Independent People's Tribunal on Human Rights Violations in Kashmir 2010) described how victims of rape had been "socially discriminated and ostracized, landing them into a traumatic state of

mind that has been permanent." The report condemned both the act of rape and its psychological effects. In these examples, human rights organizations used trauma to make moral arguments for the need to demilitarize the region and revoke draconian laws.

As we will see, these arguments have also been used by proindependence political parties to argue for justice and self-determination (*azadi*), and they have also been co-opted by pro-Indian parties such as the People's Democratic Party to argue for a more "humane" continued Indian rule.

## Turning Counterinsurgents into Victims

In other words, trauma has not only been used for progressive social justice and emancipatory political ends, such as calling for the end of occupation and militarization. As we saw earlier, Indian state institutions worked closely with organizations such as the MSF on mental health projects in the region, often with the effect of depoliticizing those efforts and transforming political agitators into medical victims. In contrast to human rights discourse, where trauma was used as evidence of the ongoing brutality of occupation, the Indian state has used medical humanitarian techniques to justify and soften ongoing military rule.

Building on the success of medical humanitarian organizations in the region, functionaries of the Indian state have also implemented a number of psychosocial and psychiatric programs to combat trauma and PTSD. The use of trauma and PTSD-related programs by Indian state agencies is somewhat ironic, given that Indian military officials attempted to undermine the validity of human rights reports throughout the 1990s as Pakistan-sponsored propaganda.[3] In response to reports of a mass rape in the village of Kunan Poshpora on February 23, 1991, by Indian security forces, for example, army officials only requested an investigation of the incident three months after its occurrence. In its report, the Press Council of India committee not only declared the medical evidence gathered by medical officials to be "worthless" but also described the criticism leveled at the Indian Army as an "invention," "totally unproven and completely untrue . . . a dirty trick," as well as "a massive hoax orchestrated by militant groups and their sympathizers and mentors in Kashmir and abroad . . . for reinscribing Kashmir on the international agenda as a human rights issue" (Asia Watch and Physicians for Human Rights 1993a). Such statements established that the language of human rights was "antinational," a perspective that is still alive today.[4]

Both rhetorically and practically, however, the Indian state—and here I refer to the state government, central government, and the Indian military—made a dramatic volte-face in its approach to humanitarianism and human rights after the Kargil War in 1999. As Mona Bhan (2014, 7) argues, the experience of the Kargil War spurred the central government—headed by the Bharatiya Janata Party—to "humanize" its Kashmir strategy. Meanwhile, at the state level a new humanitarian rhetoric was articulated by the People's Democratic Party, which came to power in Kashmir on a human rights platform in 2002, described as the "healing touch" policy. As Bhan, Duschinski, and Zia (this volume) note, "In conjunction with Mufti Sayeed's 'healing touch' policy, the 'winning hearts and minds' rhetoric treated Kashmiri resistance against Indian rule as a symptom of their widespread alienation, one that could be fixed through an optimal dose of compassion, development, and good governance." In March 2003 the government opened investigations into alleged disappearances and custodial deaths, arguing that healing "moral and historical wounds" was urgently required to promote a culture of goodwill and reconciliation in the region and rebuild civil society (Bhan 2014, 5). As Bhan (2014, 12) powerfully illustrates, the "healing touch" policy was seen, even by pro-Indian forces, as the "crying need of the hour for the proverbial common man" (see also Behera 2003). Building on Bhan's argument, I see the development of medical humanitarian interventions around trauma and PTSD in the valley as a crystallization of the "healing touch" policy.

Within the Indian military as well there was a change in the rhetoric and practices of occupation during this time.[5] Writing in 2007, a former army general, Y. N. Bammi (2007, 259), emphasized that the human rights policy of the army was zero tolerance, transparency, and strict punishment. Rather than dismissing human rights reports as a form of "antinational" propaganda as they had done earlier, greater attention was given to emphasizing care of the "people" at the heart of counterinsurgency operations (Bhan 2014). These humanitarian languages and practices were formalized as Operation Sadbhavana (Goodwill) in 1998, viewed as a cornerstone of the Indian Army's Winning Hearts and Minds (WHAM) campaign.[6]

In a doctrine published by the Army Training Command (n.d.), "winning hearts and minds," rather than conducting military operations, was seen as "the most essential aspect of successful CI [counterinsurgency] operations." WHAM was described as a "long drawn-out, sustained strategy" to ensure "a steady positive trajectory of transformation" in the population (Bhosale 2009, 11). One of the main components of WHAM is "civic

action through development projects, which would improve the quality of life of the people and promote better understanding amongst the locals" (14). "Psychological initiatives" in particular have a special place within the counterinsurgency doctrine:

> Psychological initiatives play a major role in a CI environment. *The planned management of information and other measures are important to influence the opinion, emotions, attitude and behavior of hostile, neutral or friendly groups in support of current policies and aims.* Themes for psychological initiatives should be chosen objectively, taking into account the perceptions of the selected target audience (Bhosale 2009, 27, my emphasis).

Efforts by the Indian military to "influence the opinion, emotions, attitude and behavior" of civilians in Kashmir have been wide ranging—from publicity and poster campaigns along the Jammu-Srinagar highway to the army's short-lived efforts to renovate Sufi shrines and mosques (Jaleel 2007).[7] Given that what Bhan (2014) calls "heart warfare" and "tropes of healing" have become central to military governance across the region, it is not surprising that WHAM-related campaigns have taken a biomedical and specifically psychological turn in recent years.

For example, since 2007 the J&K Police have been running the Drug De-Addiction Center (DDC) for civilians and police personnel in its headquarters in Srinagar. Echoing the language of Operation Sadbhavana, clinicians described the DDC as a "social mission" and used the language of compassion to describe their work: "The *charasi* [hashish smoker] and the *sharabi* [alcoholic] have the lowest status in our society—no one respects them," one staff member told me, "but here, we take them in and restore their dignity." Unlike private de-addiction facilities, which can cost up to 40,000 rupees a month, the J&K Police agency subsidizes in-patient treatment at the DDC, further underscoring its humanitarian mission. Patients pay a relatively modest 3,000 rupees for one month's treatment, which covers the cost of food; all other expenses, including medication, are paid for by the J&K Police. The DDC uses a combination of pharmacological, psychotherapeutic, and "penitentiary techniques"[8] to maintain patient compliance. The DDC was said to be the brainchild of the inspector general of police, S. M. Sahai, who has greatly increased the police department's social and humanitarian efforts, particularly after the 2010 uprising (Muhammad 2011).[9]

According to the administrative head of the DDC, after conducting a series of public awareness camps about de-addiction in Kashmir Valley in 2007, mental health professionals and the police realized the scope of the problem. Dr. Riyaz (a pseudonym) explained that the camp experiences established the urgent need for a de-addiction treatment center. In February 2007 an in-patient facility was established at the Police Hospital, located in the police headquarters and consisting of a single ward with a five-bed capacity, as a three-month pilot project. The project was extended for another two years, the center shifted to a separate building, and the bed capacity upgraded from five to ten beds. Dr. Riyaz was proud that the center now included recreational facilities. As of December 31, 2009, 2,500 patients had visited the center, and 175 patients had been treated as in-patients. In 2011, the center expanded again to include more beds, a Stress Management Center, and a telephone help line. The success of the DDC, measured by the long waiting lists of patients trying to get in as well as the staff's claim of relapse rates lower than the global average, spurred the police to set up two more centers in Baramulla and Anantnag. These state-funded treatment centers have also been accompanied by police-run awareness-raising programs, including camps in schools and neighborhoods across Kashmir.

While staff at the DDC highlighted the professionalism of the program and compared it to other renowned de-addiction centers in major Indian hospitals, there was an overwhelming police presence inside and outside the center. In both its composition and aims, the DDC exemplified the merging of biomedical and custodial efforts. There were several checkpoints to cross, and police personnel—who were on twenty-four-hour duty—frisked all male visitors. During my fieldwork, I witnessed several incidents where patients who infringed the rules, such as leaving the center without permission or being aggressive with fellow patients, were physically beaten by security guards on the instruction of the staff. Yet I also saw cases in which the DDC staff became the confidantes of former patients and developed affective ties.

The police department has also used psychological tools to "rehabilitate" stone pelters as a part of counterinsurgency operations. In 2011, a few months after protests during the summer of 2010 in which over 110 Kashmiri youths were killed, the J&K Police drafted a Rehabilitation Policy for stone pelters. The policy, echoing WHAM, was designed to "win hearts" and was focused on "counseling and rehabilitation" of youths (Handoo 2013). Such "rehabilitation" efforts did not replace punitive actions by the armed forces but instead

went hand-in-hand with them. For example, in the protests following Afzal Guru's hanging in February 2013, 338 people—many of them youths—were arrested in Kashmir Valley. These individuals were arrested under draconian laws such as the Public Safety Act, were "counseled," and were encouraged to pray five times a day (*namaz*) and read the Quran (Handoo 2013).

For some mental health workers involved in these projects, many who privately espoused pro-*azadi* politics, working for the police produced ambivalent feelings. Several of the clinic's staff members described the stigma they felt being on the police department's payroll and deliberately concealed their police ID cards while driving to and from work in case they were stopped by armed militias. Others questioned the subsuming of psychological techniques for counterinsurgency purposes. One mental health worker at the DDC described his discomfort at being approached by a senior staff member to participate in the stone pelter rehabilitation project. In a climate of antagonism and suspicion against the police and military, he felt that it was dangerous to expose oneself to the public as a police agent. Furthermore, he fundamentally disagreed with the aims of such a rehabilitation project, which assumed that the genuine political grievances of stone pelters could be fixed through counseling. When I asked him how he had responded to his supervisor's request, the mental health worker said that he had refused to participate. However, taking this position had a deleterious effect on his relationship with his supervisor, and he soon resigned from his post.

The work of de-addiction treatment, as imagined by the J&K Police, was to transform criminals or "terrorists"—drug addicts, petty criminals, ex-militants, and stone pelters—into "patients," who were treatable through psychological and psychiatric treatments. Perhaps more significant, the WHAM project was designed to conceal the military and counterinsurgency aims of the police under a medical and humanitarian guise. Rather than hold individuals wholly responsible for their addiction, clinicians working for the state blamed high rates of addiction on "prevailing conditions"—code for the conflict—for producing trauma and breeding corruption, which prevented the enforcement of existing anti-drug trafficking laws. This approach allowed mental health professionals working for the state to embrace a medical humanitarian role, because they did not blame individuals for substance abuse problems and offered to treat and heal them. At the same time, state institutions such as the police used psychological "rehabilitation" and counseling to transform unruly subjects into docile citizens.

## Psychiatrists as Global Experts

As I have shown, despite its work of recognizing and treating the suffering of victims of violence, medical humanitarianism in Kashmir has been directly shaped by the interests of the Indian state and military. As state government employees, Kashmiri psychiatrists—many who wanted to identify and address widespread suffering as part of their pro-*azadi* commitments but could not state their political positions openly—found themselves in a bind. This reveals another possible use of trauma for psychiatrists: it allows them to speak of political suffering in an indirect manner by using a humane, seemingly benign medical vocabulary rather than the more overt "antinational" language of human rights.

Psychiatrists I interviewed felt that the media "hype" around trauma had a positive effect by greatly increasing public awareness around mental health care in Kashmir. Practitioners were now able to offer better, more accessible, and more effective treatment to the mentally ill. In other words, the focus on trauma and PTSD had created access to mental health care not only for victims of violence but also for those suffering from other mental illnesses and developmental disabilities, which are not conflict related. For example, mental health services in the Shri Maharaja Hari Singh Hospital in Srinagar now include a sleep clinic and a center for autistic children, services that were enabled by greater public recognition and acceptance of mental health as a legitimate component of public health. However, some psychiatrists also expressed that there was a potential downside to the overwhelming focus on trauma and PTSD within mental health care in Kashmir. One psychiatrist, Dr. Irfan, argued that there was a danger in seeing "mental health as trauma"—in other words, that the overwhelming focus on trauma and PTSD may occlude the existence of other pressing problems.

Psychiatrists have also found trauma useful because it is a globally recognized form of suffering and thus can be used to legitimize and raise the status of victims of violence in Kashmir. For example, one chilly afternoon in December 2009, I sat at the Government Psychiatric Diseases hospital canteen with Dr. Ahmed and another psychiatrist, Dr. Iqbal Mir, drinking cups of hot, milky tea. Dr. Mir had been trained at the Psychiatric Diseases hospital in the 1990s but had since been working abroad. During the conversation, Dr. Ahmed told Dr. Mir that he would like to use the families of disappeared persons as a sample group of "complicated grief."[10] In so doing, it seemed that Dr. Ahmed was using the psychiatric label "complicated grief" to raise the

status of the families of disappeared persons by indicating that their suffering was akin to trauma or PTSD—which were globally recognized and seen as "worthy" of receiving attention and resources from humanitarianism. In other words, Dr. Ahmed was using a psychiatric or diagnosis—"complicated grief"—to make a political statement about the status of disappeared persons and their kin, similar to how human rights advocates use these terms to argue for the legitimacy of suffering.

The statement was also significant for psychiatric knowledge: rather than simply particularizing "universal" psychiatric diagnoses, Dr. Ahmed wanted to use a particular phenomenon—Kashmir's families of disappeared persons—to generate a new universal diagnostic category. In spite of their free use of Euro-American diagnostic terms, these moments suggest that Kashmiri psychiatrists were deeply aware of what was at stake in the production of scientific knowledge in Kashmir, specifically. For psychiatrists in Kashmir, psychiatry and biomedicine were not divorced from the particular sociopolitical milieu but were deeply implicated within it. As such, psychiatric knowledge, although universal, had to be made relevant to the specific needs of Kashmir.

In contrast to Dr. Ahmed's use of trauma toward progressive political ends, many psychiatrists simultaneously questioned the prestige and attention lavished on trauma and PTSD research. One of the critiques I heard from psychiatrists was that the diagnosis of PTSD was a sign of the practitioner's priorities rather than a transparent translation of a patient's embodied suffering. This was remarkably similar to critiques that anthropologists have made about humanitarianism: that it "indicates more about the moral sentiment of the witness than about the experience of the victim" (Fassin 2011, 204). While the global mobility and prestige that the diagnosis of PTSD offered to psychiatrists was undeniable—"PTSD is our bread and butter," a psychiatrist once told me—its deployment was controversial.

In recent years, international humanitarian organizations including the MSF, Save the Children, Action Aid, and the International Committee of the Red Cross have hired local psychiatrists to work as consultants on projects and train psychosocial workers in Kashmir. Several Kashmiri psychiatrists have almost exclusively focused on trauma and PTSD in their research; this is seen as advancing Kashmiri psychiatry to the status of a global form of expertise and indeed seemed to be an effective strategy, as Kashmiri psychiatrists have been publishing in international psychiatric journals (Dhar et al. 2007; Wani et al. 2008). However, the production of knowledge about PTSD in Kashmir was also viewed by some psychiatrists as self-promotional. One

psychiatrist in particular, Dr. Naseer Fayyaz, was seen as actively promoting trauma and PTSD for personal gain. Dr. Fayyaz had produced several videos of his community projects on PTSD, which I had the opportunity to watch over the course of my fieldwork. These videos revealed the extent to which medicine and humanitarianism have fused in "traumatized" Kashmir.

The videos produced by Dr. Fayyaz closely resembled the visual material and podcasts that organizations such as the MSF routinely produce to document and promote their work. One video began with text informing the audience that in the winter of 2005, a village called Wartego in northwestern Kashmir had been devastated by an earthquake and severe snowstorms. The text faded to a summer scene, a few months after the disaster. Amid tall green grasses and imposing mountains, images of children in tattered clothing and wrinkled and tanned men and women entered the frame. This juxtaposition of suffering Kashmiris against a beautiful landscape has become a stock image in media and humanitarian publicity tools in the post-cease-fire period, the latest in a long history of symbolic appropriation of the Kashmiri landscape that Ananya Kabir (2009, 5) has described.

Suddenly a white SUV appears, and a narrator tells us that "hope comes in the form of psychiatrists." Four or five Kashmiri psychiatrists get out of the SUV and make their way down a slope with big, confident strides. The narrator continues: "The human touch makes its presence felt in the shape of Dr. Fayyaz." Next, we see Dr. Fayyaz sitting on the grass in his pristine white coat surrounded by a group of village children. "A heart-to-heart talk, a laugh, provides the inspiration to move on," the narrator continues. Next, the camera pans to wide-angled shots of the entire village. Notebooks and medication surround the two other psychiatrists, who are wearing crisp white coats. This scene of humanitarian healing then fades to a flashback of a desolate winter scene of the same village in the immediate aftermath of the snowstorm. The psychiatrists are here again, but this time they are more warmly clad. One promises a small child that he will bring him socks and warm undershirts. Doctors distribute blankets and food to the villagers. The narrator chimes in: "Just a little satisfaction, but the journey continues."

Another video that Dr. Fayyaz produced took on the issue of PTSD more explicitly. The second video, which employed the same narrator, began with a question: "Are the psychological experiences of disaster universal?" After a brief pause, the narrator responded: "PTSD is one of the most common aftermaths of experiencing trauma or disaster." The video briefly showed the toll of recent disasters in South Asia, including the 2004 Indian Ocean tsunami

and earthquake as well as the 2001 Gujarat earthquake in which approximately 20,000 people lost their lives. Then it focused on Kashmir, which "has suffered fifteen years of conflict" as well as a devastating earthquake and snowstorms in 2005.

The next scene showed the Psychiatric Diseases hospital, which was presented as an epicenter of treatment on PTSD. First, we see a young girl who, we are told, has lost her entire family in the earthquake. She is quiet, withdrawn, her head bowed down. In the background, we hear Dr. Fayyaz's voice gently addressing her as "*beti*" (daughter), coaxing her to answer questions about her age and where she is from. She does not respond. After this scene we are shown another patient, a man in his twenties, with dark circles under his eyes, which are red from crying. Again, the practitioner is not visible, only the patient, who begs the doctor to give him some medication—sleeping pills or something. The scene continues for some time, with the young man openly expressing his anger toward the doctors for not alleviating his pain. We are led to question his sanity as well as his innocence as he veers toward a violent outburst. His outburst is cut short by the narrator, who informs us that "PTSD is not a culture-bound syndrome of the West. It affects us all."

These videos represent one example of how Kashmiri psychiatry has been transformed in the context of military humanitarianism. It also shows how experiences of violence and suffering have been translated into a professional psychiatric language of trauma and PTSD, although for contradictory purposes. As one mental health professional told me, "Some people have become very rich thanks to PTSD." In discussing these select "misuses" of trauma and PTSD, as one psychiatrist put it, there was concern that publicizing the misuses would detract from the actual good work that was being done in mental health care. Psychiatrists were also concerned that publicizing the exploitation of trauma and PTSD could once again lead to a blanket questioning of the reality of suffering in occupied Kashmir.

In light of these legitimate concerns, I want to emphasize here that what moves Kashmiri psychiatrists to use trauma and PTSD as tools in their work and research is not *only* self-promotion or a desire to be recognized as global experts. Many psychiatrists also embody a sense of social justice and use trauma and PTSD to further the recognition of suffering of Kashmiri victims of violence. At the same time, I think it is important to attend to the uneven ways that trauma is approached in Kashmir. In drawing attention to the multiple economies of trauma, however, we need not throw out the baby with the bathwater. To account for and represent the everyday reality of Kashmiris, we

need to recognize the extent of psychological suffering while simultaneously being able to critique the potential limitations of basing political claims for self-determination on medical and psychological symptoms of trauma and PTSD.

## Conclusion: Citizens as Outpatients

The merging of humanitarian, military, and biomedical impulses in contemporary Kashmir produces Kashmiri subjects as "outpatients" in need of care and discipline. While processes of medicalization have often been criticized for stripping local contexts of their political and social meaning, I have shown how psychiatric and psychological languages are suffused with political implications. Humanitarian organizations, the Indian state, and Kashmiri psychiatrists seem eager to continue to capitalize on trauma and PTSD, expanding their scope and reach far beyond the clinic. However, while the global proliferation of trauma and PTSD seems inevitable or unstoppable, I have shown how it is dependent on highly contingent local interests. In that sense, I am calling for more care in the use of these terms and attention to how they can be mobilized to radically divergent political ends.

For one, trauma and PTSD have been important to practices of political claims making, particularly because they are ways of acknowledging that living under conditions of militarization and occupation has left an indelible mark on Kashmiri lives and social relations. The simple statement that Kashmiris are traumatized is thus an empathetic gesture, a clear acknowledgment of harm against a context in which the mainstream Indian discourses often overlook the cost of the conflict on Kashmiris and reduce widespread discontent to a problem solved by development or humanitarianism. In that sense, trauma has been useful to political movements demanding *azadi* because it reflects—through a globally recognized term—a collective suffering at the hands of an unjust regime.

At the same time, trauma discourses produce uncomfortable equivalences between victims and perpetrators while also hierarchizing victims into levels of deservingness. This blurring between victims and perpetrators is potentially problematic for Kashmiri demands for justice. For example, Indian soldiers posted in Kashmir are also viewed as "victims" of trauma particularly in cases of suicide and fratricide, which have been common in recent years (Ghosh 2014). In the logic that stone pelters can be psychologically rehabilitated or that Indian soldiers are "traumatized" is a basic denial of the political

nature of the conflict and of the profound inequality that exists between victims and perpetrators.

Given the prominence or hype around trauma and PTSD in the last decade, there is also a danger that those suffering from trauma and PTSD are privileged over those suffering from nonconflict-related mental illnesses. This, in turn, may lead to victims being distinguished or hierarchized and material to goods and services being doled out differently depending on what kinds of symptoms present in the clinic. Who are the truly traumatized and thus truly worthy of care and attention? Are they Kashmiri civilians who have experienced and continue to experience physical violence and everyday humiliations at the hands of Indian soldiers? Are they the Indian soldiers, who spend long months away from their families fighting young boys with stones? Is it a young man suffering from nightmares and flashbacks after witnessing his brother's death or another young man addicted to opiates trying to cope with a broken love affair? While trauma is used as a shorthand for collective suffering, it is also used to make calculations about "good" and "bad" victims of violence and how these individuals might be transformed through the gentle hand of medical humanitarianism.

There are also questions around the continued utility of trauma and PTSD in this stage of the occupation. While the first decade of the conflict (1989–1999) saw an exponential increase in the numbers of patients suffering from trauma and PTSD, in recent years there are indications that Kashmiris are "coming out of conflict trauma" (Hussain 2009). Since the psychiatric labels "trauma" and "PTSD" have become fused with *moral* arguments for justice and political rights in Kashmir, such arguments risk being misread. The argument that Kashmiris are "coming out of conflict trauma" may be used to argue that the state is moving toward normalcy, for example. However, the drop in new cases of trauma and PTSD does not mean (or does not have to mean) an improvement in the political situation or in the mental health of Kashmiris but instead is a sign of the changing *shape* of the conflict and how it is experienced as well as changes in the psychic effects of long-term violence and occupation. While traumatic incidents—in the narrowly defined sense of directly experienced incidents of physical violence—might be on the decline, the numbers of patients seeking psychiatric and psychological treatment in Kashmir continues to rise, a process that can be read as the growing recognition of mental health care, an example of the medicalization of everyday life in Kashmir, evidence for the breakdown in cultural life and coping mechanisms, or all of the above.

To account for the continued psychic, bodily, and social weight of life under occupation, we perhaps need languages and tools that go beyond trauma and PTSD and even beyond medicine, which tends to pathologize suffering. As Derek Summerfield (2012, 521) argues, "the more the mental health field promotes its technologies as necessary interventions in almost every area of life and the more that people pick up that they are not expected to cope through their own recourses and networks, then the more that time honored ways of enduring and coping may wither." There is significant evidence to suggest that those "time honored ways of enduring and coping" are fading and are increasingly being replaced by visits to counselors and psychiatrists.

While the language of trauma and PTSD offers a way for Kashmiris, for the first time, to have their experiences of occupation recognized and legitimized on a global scale, the emancipatory possibilities of trauma and PTSD are limited by the fact that it is being used—and will continue to be used—as a technique of rule to transform former "terrorists" into "patients." Giving up trauma does not necessarily mean giving in to forced state narratives of normalcy. However, for a truly emancipatory politics, we will need to go beyond a language of trauma and its attendant notions of victimhood.

## Notes

1. According to the American Psychiatric Association's *Diagnostics and Statistical Manual of Mental Disorders* (*DSM*), PTSD is defined by two major criteria: an exposure to a traumatic event and a set of psychiatric symptoms that occur (or recur) after the event. The traumatic experience is defined in the *DSM-IV* as an event involving "actual or threatened death or serious injury or a threat to the physical integrity of self or others" (American Psychiatric Association 2000, 427). After such an experience, a person meets the criteria for the disorder if symptoms from each of three general categories are present: (1) reexperiencing the traumatic event through nightmares, flashbacks, and/or intrusive thoughts or images related to the event; (2) symptoms of hyperarousal such as difficulty falling or staying asleep, difficulty concentrating, and exaggerated startle response; (3) symptoms of withdrawal such as avoidance of reminders of the event, emotional numbing, or feelings of detachment.

2. According to the MSF, "it was on the killing fields of Bosnia in the 1990s that MSF volunteers recognized that it was not enough to meet the physical needs of people caught up in conflict" (Médecins sans Frontières 2004). From 1993 to 1997, the MSF implemented a program to address the psychological trauma produced by the Bosnian War and since then has conducted mental health interventions in more than forty

countries. While most of the MSF's global mental health programs exist within emergency medicine, the project in Kashmir—which lasted for eleven years—was somewhat unique as a stand-alone mental health program.

3. Although I use shorthand such as the "Indian military" and "Indian state," I want to note the multiplicity of actors who are employees or agents of the Indian state in Kashmir.

4. Since the start of the armed struggle, political activists and human rights advocates have been harassed and arrested under the controversial Public Safety Act, one of the most draconian laws applicable in Indian-controlled Kashmir. Despite the difficulties of gaining access to border regions and continued state surveillance, in the last fifteen years local and international human rights organizations have continued to publish damning reports against the actions of Indian security forces.

5. Some policy analysts such as Arpita Anant have argued that the principle of minimal use of force and the recognition of people as "the center of gravity" in any counterinsurgency operation have been a fundamental principle adopted at the height of counterinsurgency operations (Anant 2011, 5–6). Many in Kashmir speculate that the military's strategy of using state-sponsored counterinsurgency paramilitary groups from the mid-1990s on—which operated as a secret, illegal army composed of former or "reformed" militants—was an attempt to restore the Indian Army's tarnished image. In other words, the army increasingly outsourced abuses and human rights violations to unaccountable "renegade" forces, who in due time themselves became the subjects of human rights violations and public anger.

6. Historically, the phrase "hearts and minds" originated in Britain's counterinsurgency campaign in Malaya (1948–1960). The phrase represents a supposedly less coercive approach to counterinsurgency that emphasizes the importance of using "minimum force." Paul Dixon (2009) has argued that this phrase does not accurately described Britain's highly coercive campaign in Malaya.

7. Other WHAM efforts include establishing "goodwill" schools and computer and vocational centers and building tube wells. See also Bhan (2014).

8. Foucault (1977, 19) includes "obligatory work, moralization, correction" as penitentiary techniques.

9. In May 2014, the J&K Police organized a counseling session for "stone pelting youth" in Srinagar. The police department routinely publicizes its medical humanitarian efforts on its Facebook page, Police Media Centre, Kashmir.

10. As per psychiatric knowledge, "complicated grief" is a condition in which the symptoms of grief and loss may linger or become debilitating with time. Unresolved, protracted, complicated, or traumatic grief includes features of both depression and PTSD. The most characteristic symptoms are intrusive thoughts and images of the deceased person and a painful yearning for his or her presence. Other complications are denial of the death, imagining that the dead person is alive, desperate loneliness and helplessness, anger and bitterness, and wanting to die.

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